Client Face Sheet

1 Patient Name _____
Last First Middle Initial Nickname

2 Address _____
City State Zip

3 Home Phone: ( ) _____ 4. Work Phone: ( ) _____ Ext #: _____

5 Soc. Sec. #: _____ 6. Birthdate: _____ Age: _____ 7. Sex: M F 8. Marital Status: S M D W

9 Employer: _____ Phone: ( ) _____ Occupation: _____

10 Student/School: _____ Full Time _____ Part Time _____

11 If dependent children, are guardians Married Separated Divorced Other

12 Religion _____ 13. Referred By: _____

14 IN CASE OF EMERGENCY NOTIFY: _____ Relationship: _____ Phone #: ( ) _____

Financially Responsible Party (Guarantor) Information
(if same as patient, only complete items 6, 7, and 8)

1 Guarantor Name: _____ Birthdate: _____
Last First Middle Initial

2 Guarantor Address: _____

3 Guarantor Relationship to Patient (circle one): Spouse Mother Father Sibling Relative Friend Other

4 Home Phone: ( ) _____ 5. Soc Sec. #: _____ 6. Derivers Lic. #: _____

7 Guarantor's Employer: _____ Work Phone: ( ) _____ Occupation: _____

8 Spouses Name: _____ 9. Spouse Work Phone: ( ) _____

***** Do You Have Insurance? Yes ___ No ___ (If yes, please complete the following)

1 Primary Insurance Co. Name: _____ Phone: ( ) _____

Insurance Co. Address: _____

2 Subscriber's Name: _____ 3. Relationship to Pt.: Self Spouse Parent Other

4 Birthdate: _____ 5. Group ID #: _____ 6. Soc. Sec. #: _____

7 Secondary Insurance Co Name: _____ Phone: ( ) _____

Insurance Co. Address: _____

8 Subscriber's Name: _____ 9. Relationship to Pt.: Self Spouse Parent Other

Employer: _____ Work Ph: ( ) _____ Occupation: _____

10 Birthdate: _____ 11. Group ID #: _____ 12. Soc. Sec. #: _____

13 Any Other Insurance? _____

ASSIGNMENT OF BENEFITS: I hearby authorize and request my insurance to pay directly to Jamie Kobsar, MA, LPC the the amount due for services rendered to me or my dependent.

RELEASE OF INFORMATION: II authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered to me or my dependent. This consent is subject to recovation at any time, except where action has already been taken on the basis of this release. Unless revoked eaerlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject to state and federal confidentiality requirements.

Signed: _____ Date: _____
Insured Parent/Guardian

GUARANTOR AGREEMENT: I AGREE TO TAKE FULL RESPONSIBILITY FOR THE ENTIRE AMOUNT DUE FOR ANY AND ALL SERVICES RENDERED BY Jamie Kobsar, MA, LPC. If provider is contracted with the insurance company, I will be responsible only for the co-pay, deductible, and non-covered services as determined by the insurance plan:

_____ _____
Guarantor Signature or Patient Signature (if patient is guarantor) Date

PATIENT RELEASE OF INFORMATION TO GUARANTOR/THIRD PARTY AGENCY: I authorize Jamie Kobsar, MA, LPC to release my financial information to my guarnator or third party agency (in case further collection assistance is required)
I do ___ Do not ___ want a copy of this release.